

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001914  
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. 170 Primary Registration District No. Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Laclede</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Stoutland</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Stoutland</b> <b>0530</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home in Stoutland</b>		Length of stay in 1b <b>unknown</b>	d. STREET ADDRESS (If outside, give location) <b>Stoutland</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>May</b> Last <b>Burke</b>	4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1959</b>
---	---

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1887</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
-------------------------	----------------------------------	---	---	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (City and state or country) <b>Floral, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	---	---	--

13a. FATHER'S NAME <b>George Freeman</b>	13b. MOTHER'S MAIDEN NAME <b>Ada Bates</b>	14. NAME OF HUSBAND OR WIFE <b>Jack Burke</b>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Freeman Burke</b>	Address <b>Stoutland, Missouri</b>
--	-------------------------------------	---------------------------------------	---------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apparent Heart Ailment</b>	INTERVAL BETWEEN ONSET AND DEATH <b>43:4</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (or **her condition was given by physician (had M.D. for 40 years) she had been treated for high stroke before**)

19a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>—</b>	19c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>	20e. CITY, TOWN, OR LOCATION <b>—</b>	COUNTY <b>—</b>	STATE <b>—</b>
---	--	--	--------------------	-------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. CITY, TOWN, OR LOCATION <b>—</b>	COUNTY <b>—</b>	STATE <b>—</b>
--	--	--	--------------------	-------------------

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **8:35 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Hella L. Hlay Food Registrar</b>	22b. ADDRESS <b>242 Taylor, Lebanon, Mo.</b>	22c. DATE SIGNED <b>2-4-1959</b>
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb 5, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Stoutland Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Stoutland, Missouri</b>
--	---------------------------------	---	---

24. FUNERAL DIRECTOR <b>Dorsey M. Howe Lebanon, Mo.</b>	ADDRESS <b>—</b>	25. DATE RECD. BY LOCAL REG. <b>2-4-1959</b>	26. REGISTRAR'S SIGNATURE <b>Hella L. Hlay</b>
--	---------------------	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
-57

Date Filed FEB 9 1953

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Dorsey M. Howe*.....

Licensed Embalmer No. *4222*.....

P. O. Address *Lebanon*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.